

## TRANSFER REPORT : Older Children and Adults

Referring Program:.....

Audiologist: ..... Date: .....

Referral to Cochlear Implant Program: .....

### Recipient Particulars

Surname		First name	
Date of birth		I.D No	
Name of mother		Name of father	
Residential address			
Postal address			
Contact person	Cell	Business / home	Email

### Case History Information

	Right ear	Left ear
Age at onset of hearing loss		
Date of diagnosis of hearing loss		
Etiology		
Duration of deafness before implantation		
Use of hearing aids		
Pre-operative speech perception test scores		

### Warble Tone Freefield Thresholds (pre-implant)

Date:

	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									

### Implant History

	Right	Left
Date of initial surgery		

Implanting Surgeon									
Audiologist									
Hospital									
Implant Model									
Implant Serial Number									
Comment									
<b>Sound Processor History</b>									
	<b>Right</b>	<b>Left</b>							
Initial stimulation date									
Current Processor Model									
Serial number									
Magnet strength									
Coil									
Cable									
Remote /App Connectivity									
<b>Mapping</b>									
	<b>Right</b>	<b>Left</b>							
Speech coding strategy									
Mode									
Rate									
Maxima									
Pulse width / pulse characteristics									
Pre-processing									
Electrodes deactivated									
Comments:									
<b>Warble Tone Freefield Thresholds (most recent post-implantation)</b>									
Date:									
	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									
<b>Speech Perception Scores</b>									
Date:									
Test Items	Presentation Recorded/Live	Presentation Level	Right score	Left Score	Bimodal/Bilateral				

<b>Recommendations</b>					